AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Speech-Language-Hearing Clinic
516 High Street, MS 9171
Bellingham, WA 98225
Ph: 360.650.3881 Fax: 360.650.4334

Please complete all sections of this form.

Client Name: _____ **Date of Birth:** _____

1. Records To/From

☐ Records are to be released **TO** WWU Speech-Language-Hearing Clinic (see address/phone/fax above)

☐ Records are to be released **FROM** WWU Speech-Language-Hearing Clinic

From Organization/To Recipient Name: _____
Affiliation to the client: _____
Address: _____
Phone: _____ Fax: _____

2. Nature of Information to be Disclosed

My initials authorize release/disclosure of my personal health information as indicated below.

PLEASE INITIAL NEXT TO ALL THAT APPLY:

_____ Evaluation Reports
_____ Treatment notes
_____ Only records related to this condition (specify): _____
_____ Other: _____

Sensitive Information in the following categories MUST be initialed to be released:
_____ Sexually transmitted diseases, antibody test results and related records, including pap smear results
_____ Reproductive health related records
_____ HIV/AIDS related records
_____ Behavioral or mental health services
_____ Drug/alcohol related records
_____ Other: _____

If you want the above records to be restricted to a specific period of time, please indicate dates:
Only release the records initialed above created during the time period of: _____ to _____

3. Purpose of Release/Disclosure Request

The purpose of releasing/disclosing the records is: **PLEASE INITIAL NEXT TO ALL THAT APPLY.**

_____ Client's personal use
_____ Continued treatment or monitoring
_____ Transfer of care
_____ School
_____ Legal
_____ Other: _____

4. Expiration of Authorization

This authorization will expire 90 days from the date of signed unless a different date is requested below:
The patient's preferred date this authorization is to expire is: _____

Note: If the disclosure is to an employer or financial institution, state law prohibits the expiration date from being longer than 1 year after this authorization is signed.

You may revoke this authorization at any time prior to the 90 days by notifying the Speech-Language-Hearing Clinic by providing a written request electronically, by mail, in person, or by fax. This authorization will cease to be effective on the date the revocation is received except to the extent action has already been taken in reliance upon it, or per any exception noted in the Clinic's Notice of Privacy Practices.

5. Client Authorization

a) I expressly and voluntarily authorize the release/disclosure of the records initialed in Section 2 for the purpose initialed in Section 3 to the party(ies) listed in Section 1 of this form.
b) I understand that once these records are released pursuant to this authorization, the recipient may not be obligated by federal or state law to protect them. The WWU Speech-Language-Hearing Clinic has no control over re-disclosure.

_____ _____

Client/Personal Representative Signature **Date**

_____ _____

Personal Representative's Name (PRINT) **Relationship to the Client**

Note: If the information requested to be released is behavioral/mental health information and pertains to a child under the age of 13, parent/legal guardian signature is required. A personal representative may be required to provide appropriate documentation to demonstrate authority to act on behalf of the client.

6. Notice to Recipient Regarding Redisclosure of Sensitive Information

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.